

## **WWW.**ATLANTICDIVINGTEAM.COM Participant Waiver & Emergency Medical Form

Diver's Name	Birth date
Class/Program Level	Date
Street Address	Phone # (H)
City, State, Zip	Phone #(W)
E-mail	Phone #(cell)
Occupation (Dad)	(Mom)
The Atlantic Diving Team offers some classes and program equipment and/or participation in certain programs that you	ns on a limited basis. There are certain risks inherent in the use of a should consider before you begin such activities.
understand that participation can involve physical activity,	gned on behalf of our minor dependents and ourselves (collectively, "our") which could result in injury. The undersigned also understands that use of the class or program is being conducted and that use will be strictly under
program, and with the understanding of the risks involved i and heirs agree to release and forever discharge the Atlantic	the programs, and Martin County allowing use of its facilities for this in our participation, the undersigned on behalf of ourselves, our dependent on Diving Team and the Martin County, their officers, directors, employees or claims for loss or damage resulting from an injury or damage which classes or programs, or use of the facilities.
Print Signature:	Date: iver or Parent (if minor)
_	ncy Medical Form
authorize and consent to Atlantic Diving Team ("Authorize medical or surgical diagnosis or treatment and hospital or e participant under the general or special supervision of any provisions of the Medicine Practice Act or a dentist license acute general hospital holding a current license to operate a understood that this authorization is given in advance of an except as expressly limited below, is given to provide authority the exercise of his best judgment may deem advisable. It is telephone at the numbers listed below prior to rendering trewithheld if the undersigned cannot be reached. If the Authority director or employee of said corporation or its affiliates. It is charges for the abovementioned diagnosis, treatment or hospitals.	of ("Participant"), do hereby and Party"), obtaining for the Participant any x-ray examination, anesthetic, remergency room care facility ("Medical Facility") care to be rendered to the member of the medical staff and emergency room staff licensed under the doubter the provisions of the Dental Practice Act and on the staff of any a hospital from the State of Florida Department of Public Health. It is y specific diagnosis, treatment or Medical Facility care being required and cority and power to render care which a Physician and Surgeon or Dentist in understood that effort shall be made to contact the undersigned by eatment to the participant, but that any of the above treatment will not be porized Party is a corporation this authorization shall include any officer, is further understood that I (we) the undersigned are responsible for all spital care.
Limitations (if any):	
Date: Signature:	
THIS CONSENT SHALL REMAIN EFFECTIVE UNTIL	:
MEDICAL INFORMATION: Birth date	Last Tetanus Toxoid Booster
CONTACT PHONE #: Print Father's Name	Phone ()
Print Mother's Name	Phone ()
Physician OR Christian Practitioner:	Phone:()
Known Allergies to drugs or foods:	
Insurance Co:	Policy Number: